BLUEPRINT FOR CONTRACTING FOR MENTAL HEALTH SERVICES FOR JAIL DETAINEES WITH MENTAL ILLNESSES

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ACKNOWLEDGEMENTS

In April 1993 the Center for Mental Health Services entered into an interagency Memorandum of Understanding with the National Institute of Justice and the National Institute of Corrections. This agreement provided the mechanism through which these federal agencies could work together to accomplish the mutual goal of providing quality mental health care in correctional settings.

As part of the MOU between the Center for Mental Health Services, the National Institute of Justice and the National Institute of Corrections, a meeting of experts was convened in September 1994 to develop a roadmap that would assist jail administrators to contract with mental health agencies for services in local jails.

We gratefully acknowledge the 19 member work group who contributed their knowledge, insights and practical experiences to this project. Special thanks to Steven Ingley, American Jails Association and the many jail administrators who provided thoughtful feedback to earlier drafts.

We are also grateful to the federal staff who provided vision and direction; to Susan Salasin, Division of Program Development and Special Populations and Larry Rickards, Ph.D., Homelessness Programs Section of the Center for Mental Health Services and to Michael O'Toole and Linda Woods of the National Institute of Corrections Jails Division. Special thanks are due to Henry J. Steadman, Ph.D., Bonita M. Veysey, Ph.D. and Suzanne Morris of Policy Research Associates, Inc., who were responsible for organizing the meeting and writing the "Blueprint."

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Introduction

In 1991, there were approximately 3,353 jails in the U.S. From 1980 to 1992, the number of persons in jail on any given day in the United States increased from 158,394 to 444,584 (United States Department of Justice, 1993). Further, U.S. currently process approximately 10.1 million admissions per year. In 1990, U.S. jails were functioning at 111 percent capacity overall, and many individual jails were substantially over this figure. Jail overcrowding is at epidemic proportions throughout the U.S.

Among the burgeoning populations in U.S. jails are persons with mental illnesses. A recent survey of male jail admissions in Cook County, IL, found that 6.1 percent had a current psychotic illness and were in need of treatment services (Teplin, 1994). Among female Cook County detainees, the estimates of mental illness were even higher. Fully 11.2 percent of the female detainees had a current mental illness of schizophrenia or affective disorder (Teplin, unpublished). In the same study, Abrams and Teplin (1991) found that 58.3 percent of the persons with major mental illnesses were currently alcohol abusing/dependent, while 33.3 percent had current co-occurring drug abuse/dependence.

On a national level, this would indicate that nearly 700,000 admissions to U.S. jails in 1990 were individuals with acute and severe mental illnesses, and a significant proportion of these requires specialized substance abuse services.

The "Blueprint for Contracting for Mental Health Services for Jail Detainees with Mental Illnesses" represents an effort to develop guidelines and principles that local sheriffs and jail administrators, community mental health providers, and communities can use to ensure the delivery of appropriate mental health services in jails and assist in establishing community linkages. There is no one best way to provide mental health services. Jails and local communities differ substantially from place to place. What works best depends on the special set of circumstances in each community. Nonetheless, there are basic principles for developing services and some general components for contracted services that have broad application. Therefore, the goal of this document is to provide direction and suggestions that are flexible enough to be adapted to any jail or community.

This document is a "blueprint" for a cooperative agreement between county or municipal sheriffs and/or jail administrators and local or national mental health service providers. The blueprint is intended to outline respective roles and responsibilities of jails and mental health service agencies in the process of coordinating for the services and care of jail detainees with mental illnesses. Although the details of such an agreement will necessarily reflect the needs of a specific community, the unique features of the parties entering the agreement, the needs and

wishes of the consumer, and other local circumstances, the goal will be the same -- to assist jail detainees with mental illnesses in continuing or obtaining the services which they require. Throughout this document, we have included consumer advocates as important participants in the planning and delivery of mental health services for jail detainees. In many jurisdictions, their unique perspectives have been found to be extremely useful in developing and implementing services.

To establish appropriate services for persons with mental illnesses who are detained requires that the jail be seen as but one agency in a continuum of community services. To assist the integration of the jail into the community and to help sheriffs and jail administrators negotiate for appropriate services, many different formal and informal mechanisms may be used. In small communities, letters of agreement or memoranda of understanding establishing priorities and cooperation among parties may be sufficient to get necessary services. In larger communities or jails, formal contracts can be developed with local mental health agencies to provide services in jail or to provide follow-up care upon release or as a component of diversion. Contracts can also be developed with large for-profit providers to ensure that specific services are available.

This document contains basic principles guiding the provision of services, core elements in the development of formal agreements, and a model contract. In addition, an example of a letter of agreement that is an actual document edited only to remove the identifying information is included in Appendix A.

Initial Decisions

In order to accomplish the goal of providing appropriate mental health services to jail detainees, it is suggested that the parties involved consider and reach agreement on the following factors *prior to contracting*:

- *Integration of services.* The jail, as a community-based facility, should be considered an integral part of the local social and health services systems. Prior to contracting, the participating parties should come to agreement on which key agencies need to be involved in order to provide comprehensive services in jail and integrated services upon release. Key organizations may include the local community mental health authority and service provider agencies, the Sheriff's and jail administrator's offices, the substance abuse authority and service provider agencies, the local department of social services, the probation department, and health care and housing provider agencies. In addition, law enforcement, local judiciary, public defenders' office and district attorney's office representatives may also be appropriate. It is important to note that services may be provided by volunteer organizations or individuals in smaller communities. These representatives should be included where appropriate.

- *The main goal.* The primary goal of mental health treatment in jails is the *safety* of the detainee, other inmates and custodial staff. However, the jail may also be seen as a site for more general public health interventions. Parties should consider what their goals will be given their history and specific community needs.

- *Essential services.* Generally, inmates are briefly held pre-arraignment, after not meeting bail, or while serving sentences of less than one year. Some mental health services are necessary to meet Constitutional levels of adequate care. Key services at this point include *identification* of persons with mental illnesses through routine screening and follow-up evaluations, and *stabilization* of the individual through crisis intervention services. Other services can be added to enhance the overall quality of care provided in the jail. For example, to facilitate the movement of persons with mental illnesses back into the community or the transfer to a prison setting, *discharge planning* and case management services are important. In addition, attention may be given to opportunities for referral for short-term detainees who may be "revolving door" misdemeanants. Sheriffs and/or jail administrators and mental health providers should consider what services are considered essential in the jail.

- *The characteristics and needs of those being served.* Before designing a contract, it is important to know to whom these services will be provided. Persons with mental illnesses who come into contact with the criminal justice system are a *heterogeneous* group. To understand their needs, a complete discussion of this issue should focus on the specific characteristics of this population, including the degree of severity of mental illness, types of crimes committed, typical precipitating events, and the *special needs of*

subgroups within the population, such as women, homeless persons, and persons with mental illnesses and substance abuse problems.

- *The resources needed.* Individuals with mental illnesses who come into contact with the criminal justice system may be diverted into the mental health system or treated within the criminal justice system. Information should be available on the *range and type of mental health services* needed by individuals both in the community and in the criminal justice system, and the *human and fiscal resources* needed to support these services.

- *Desired outcomes.* Parties to the contract and interested constituent groups are likely to have different outcomes in mind, when designing mental health services. It is important to identify and specify the desired *outcomes* of any intervention for the criminal justice system, the community, and the individuals involved.

- *The potential barriers.* Obstacles to providing appropriate care for persons with mental illnesses in the criminal justice system include human and fiscal constraints, organizational ownership (turf) issues, *lack of information* on the part of the criminal justice system about effective mental health programs and how to implement them, and *lack of understanding* on the part of the mental health services system about the demands and constraints of the criminal justice system. It is particularly important to clarify potential funding streams and any impediments to payment of services, as well as designating responsibility for administration, operation and payments. These barriers should be identified and ways to overcome these barriers highlighted.

- *Public misconceptions*. Public misunderstanding regarding the role of the jail, its mandate and its limitations in the care of detainees with mental illnesses can derail any jail mental health initiative, whether it is jail- or community-based. It is important to inform the general public of not only a new initiative's rationale, purpose and goals, but also the limits of what can be expected of mental health treatment in the jail.

Core Elements

The following factors represent the core elements which should be present to ensure that jail mental health services are as effective as possible.

- *Integrated services* at the community level with police, corrections, mental health, housing and entitlements involved and a high level of cooperation between all parties to ensure continuity of care.

- *Regular meetings* of all the key players from each of the agencies.

- *Boundary spanners* who are responsible for linking the judicial, correctional and mental health components of mental health services for jail detainees.

- *Court-based or jail-based diversion programs* or procedures for persons with mental illnesses should be developed to divert non-violent individuals with mental illnesses out of the jail setting and into mental health treatment as soon as possible.

- *The essential mental health services of screening, evaluation, crisis intervention, and discharge planning*, identified in the American Psychiatric Association's Task Force on Psychiatric Services in Jails and Prisons' report, should be available to persons who are not appropriate for diversion. Special emphasis should be placed on the development of linkages to the community via discharge planning.

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NOTE: Depending upon the specific needs in your community, a comprehensive contract such as that set forth below may not be necessary. See Appendix A for an example of a shorter "interagency agreement" that might better suit the needs of your community.

I. PARTIES: Designates the parties entering into the agreement.

II. WHEREAS: States the ability of each agency to contract (separate statement for each). For example:

WHEREAS, the mental health agency is a corporation with substantial experience in the field of providing total mental health care for services for persons incarcerated in public jails, and has certain similar ongoing contracts and programs ...

WHEREAS, the jail is a local confinement facility that has custodial authority over adults pending adjudication and for sentences of typically up to two years. AND in the provision of secure and safe detention, the Sheriff has the statutory and constitutional duty and responsibility to provide necessary and proper psychiatric services for persons remanded to his care, custody and control within the county correctional system ...

III. TERM OF AGREEMENT: States the duration of the agreement, usually for a minimum of one year.

IV. PURPOSE: States the purpose. For example:

To encourage a working agreement/contract between the county jail and local/national mental health service provider(s) to ensure that persons with mental illness who come into contact with the jail will have access to and will receive the services they require.

V. GUIDING PRINCIPLES: States the guiding principles of the contract/agreement. For example (much of the information below has been adopted from the APA Standards for Psychiatric Services in Jails and Prisons (1989)):

A. The fundamental policy goal is to provide the range of mental health services necessary to ensure that persons with mental illnesses do not deteriorate while in custody due to lack of care, consistent and in compliance with the evolving body of case law and Constitutional provisions as defined by Supreme Court decisions.

B. Jail detainees with mental illnesses will have fair and equitable access to appropriate mental health services and the facility/agency will not adhere to any form of exclusionary criteria that would prevent an otherwise eligible individual from participating in treatment. Furthermore, it is agreed that in the performance of this contract no person shall on the grounds of race, creed, color, gender, age, sexual orientation, disability, religious affiliation or national origin, be excluded from participation in, be denied the benefits of, or be subject to any discrimination under any programs or activity sponsored by the parties.

C. Both mental health and corrections staff will participate in arranging cross-training to educate each other and facilitate an understanding between the two systems on the specific issues facing each. Because mental health providers are working in a detention facility, it is particularly important for clinicians and mental health staff to understand how the criminal justice system works and the specific demands and procedures of corrections work, including security procedures, classification, and a hierarchical organizational structure. Training for corrections staff should include characteristics of mental illnesses and how to make appropriate referrals, as well as what services are available in the local area and how to access them, understanding confidentiality statutes and mental health law, and the goals and outcomes of treatment.

D. It is essential that both corrections and mental health staff have a clear understanding about what information can be shared about individuals and of the rationale, both ethical and legal, for the policies. The special needs presented by the jail, especially in relation to security, require certain modifications of the usual principles of confidentiality. In particular situations, the rights of the patient to privacy and confidentiality must be weighed against the needs of other inmates as well as the legitimate institutional needs of safety and security.

E. The patient will participate, to the extent possible, in decisions about evaluation and treatment. Service providers will offer to discuss with their patients the nature, purpose, risks, and benefits of the potential types of treatment. Policies concerning the right to refuse treatment will conform with the rules and procedures of the jurisdiction in which the facility is located. Specific, written policies will be developed and maintained in regard to issues relating to confidentiality and as to the degree to which confidentiality of information can be assured.

F. Discharge planning for detainees with mental illnesses will start early and will be integrated into the ongoing evaluation and treatment process. All key players will participate in discharge planning to insure comprehensive and continuous services to persons with mental illnesses preparing for release.

G. **Where feasible and appropriate**, the jail and the mental health agency(s) will participate in accreditation programs to further enhance the quality of care offered and received and shall, at all times during the term of this agreement, provide a standard and quality of mental health care designed to meet those standards developed by organizations, such as the National Commission on Correctional Health Care, the American Correctional Association Commission on Accreditation for Corrections, the American Bar Association and the American Psychiatric Association. Any deficiency in the performance of mental health services in the county jail system resulting in notice from any regulatory or accrediting organization may constitute a material breach of this agreement and shall be rectified immediately.

VI. RESPONSIBILITIES: Lists the responsibilities of each agency and the clients to be served, the services available to clients, the site of services, the times available, and the manner in which these services can be obtained. For example:

A. The mental health service agency agrees to provide the following mental health services when appropriate:

1. Screening - assist in identifying and evaluating detainees for mental illness during the intake/booking stage. This includes:

   a) training for corrections officers in initial mental health screening and suicide prevention

   b) in-depth mental health screening within 24 hours of referral

   c) follow-up mental health evaluation

2. Diversion - provide information as requested by jail staff or court personnel to assist them in identifying the detainees most in need of, and most likely to, benefit from community based alternatives to incarceration. This may include:

   a) assigning pretrial mental health specialist(s) to work with the jail staff and/or county court personnel in arranging for alternatives to incarceration; or

   b) creating a "Jail Diversion Program" based in the jail or the court to handle cases appropriate for diversion (see Steadman, et al., 1994).

3. In-Jail Mental Health Services - provide early access to jail-based crisis intervention and short term therapy to increase potential for successful pretrial bond compliance in community-based mental health services and provide comprehensive mental health treatment including the following:

   a) suicide prevention

   b) psychotropic medication and monitoring

   c) individual or group psychotherapy

   d) substance abuse treatment

   e) inpatient hospitalization

4. Discharge Planning - throughout the term of incarceration, provide family education, behavioral counseling, life skills development, and linkage to case management, housing and social services to insure continuity of care upon release.

B. The correctional/law enforcement agency agrees to:

1. Adjust its intake and pretrial procedures for purposes of identifying criminal defendants with mental illness and those having a prior history of receiving mental health services;

2. Provide work space and other resources necessary for the joint identification of detainees/offenders' needs for mental health services and preparing reports to the criminal courts;

3. Provide updated lists of detainees so that the mental health agency staff is able to identify current mental health clients and arrange linkage on a timely basis to case management services; and

4. Provide sufficient and timely data to enable the mental health agency to track client status throughout the criminal justice system during the pretrial stage.

5. The jail will be responsible for security and supervision of the detainees at all times and may share responsibility for the following services:

   a) routine mental health screening by a booking officer at intake

   b) referrals for in-depth mental health evaluation when needed

c) diversion

d) suicide prevention

e) special housing area

f) discharge planning

C. Joint responsibilities of the agencies : Ensuring that detainees with mental illnesses receive appropriate services is a *joint responsibility* of the contracting agencies.

1. To insure the safety of all inmates and staff at all times during the course of detention and treatment,

2. To insure that all detainees with mental illnesses are identified and have access to appropriate mental health services.

3. To identify and adhere to requirements or standards regarding confidentiality of client information, such as requiring the client's permission to release information to either agency.

4. To insure that adequate discharge planning takes place so that follow-up care for detainees with mental illnesses is available upon release.

VII. DETAINEE RIGHTS AND RESPONSIBILITIES: Describes the rights and responsibilities of detainees. For example:

A. No individual will be detained longer than the term of his/her sentence or otherwise penalized by the criminal justice system or the mental health agency for terminating status as a recipient of mental health services, provided they continue to fulfill essential conditions specified in the plea agreement.

B. An individual who completes his/her sentence and who ceases receiving services from the mental health agency will, to the extent possible, have the opportunity to re-establish the service relationship with the mental health agency, or alternatively to make similar, equivalent arrangements with another agency chosen by the individual.

VIII. CONFIDENTIALITY: In light of the special considerations presented in regard to confidentiality in a jail setting, it is particularly important that specific, written policies be developed and maintained. Recognizing the inevitable and indeed necessary loss of

privacy in jails, the usual principles of psychiatric confidentiality should generally apply in all aspects of the delivery of psychiatric services. However, the special needs presented by the jail setting, especially in relation to security, require certain modifications.

In general, the written policy should contain guidelines and procedures for the dissemination, access, storage and safeguarding of information and records pertaining to inmates in the jail. Specific procedures regarding confidentiality should be developed in the following areas:

A. Dissemination of Information to the Public. For example:

The following information may be disseminated to the public unless, for the protection of the individual concerned or at the request of a criminal justice agency or agency thereof, it has been requested that no information be released. (Followed by list of information such as name, race, date of arrest and confinement, current charge, etc.)

B. Dissemination of Information to Criminal Justice Agencies or Agents Thereof.

1. The following information may be disseminated: (list name, race, current charge, etc.)

2. That additional information listed below. List any other information, such as:

Information concerning an inmate's medical, dental, or psychological status, upon order of a court; at time of transfer to the Department of Corrections detention facility; as may be required during the conduct of an official investigation; or as may be required to ensure an inmate's physical and mental health.

C. Dissemination of Information to Mental Health Provider

Consistent with Paragraph VI.C.3 of this document, the jail administration and/or Sheriff's office may want to consider developing a formal agreement for the express purpose of information exchange. This agreement should explicitly state what information may be communicated, under what circumstances (e.g., only after the detainee has signed a release of information form), when and by whom.

D. Dissemination of Information to Attorneys representing an accused, convicted, or sentenced individual at the jail.

E. Dissemination of Information to Non-Criminal Justice Agencies and Individuals.

Unless specifically provided for in the Standard Operating Procedure, no information pertaining to inmates confined in the jail will be released to any non-criminal justice agency or individual without specific approval of the designated authority or as the result of a court order.

F. Record of Dissemination: Outline record-keeping procedure.

G. Access: List parties authorized to access specific information.

H. Storage and Safeguarding of Records.

IX. IMPLEMENTATION AND EVALUATION:

A. Describes the issues related to implementation and evaluation such as:

1. How the agreement can be modified, amended or terminated;

2. How problems in implementing the agreement will be resolved; and

3. How the contract/agreement will be reviewed to determine if the policies and procedures are effective in helping jail detainees with mental illnesses access services and maintain continuity of care in a manner that is satisfactory to the individual, other inmates, the mental health agency(s), and the jail.

B. Designates liaisons to oversee, facilitate, and periodically monitor and evaluate the contract/agreement.

X. PAYMENTS:

Because mental health services in jails are not reimburseable by MEDICAID or third-party payors, they typically are paid from within the county mental health or the Sheriff's budget. This situation can create disincentives to providing services. To overcome these barriers, localities should investigate other sources of funding and opportunities to combine funding streams.

A. Responsibility and mechanisms for payments for services should be clarified.

APPENDIX A

An Example of an Interagency Agreement to Provide Services for Jail Detainees with Mental Illnesses[1]

[1] The following Letter of Agreement is an actual document that is currently being used successfully in one jurisdiction. All identifying information has been removed. The contents of the document reflect general principles, but also have some characteristics that are unique to the community and service system that created it. The development of a Letter of Agreement in other communities will require some adaptation of this model.

WE, the undersigned agencies, having joined together for the purpose of investigation, discussion and strategic planning for the care of the severely mentally ill in the COUNTY JAIL, hereby agree to work cooperatively to ensure that the mental health needs of the severely mentally ill who are incarcerated at the COUNTY JAIL are met.

IT IS FURTHER AGREED, that all agencies will appoint a contact person to communicate with other social service agencies and service providers and each agency agrees as follows:

THE MENTAL HEALTH AGENCY 1 AND THE COUNTY GOVERNMENT agree to provide treatment to persons at the jail in need of mental health care. All participating agencies agree that the MENTAL HEALTH AGENCY 1 and THE COUNTY will be responsible for the provision of this treatment. The Medical department at the jail will also be responsible for notifying the liaison once a consumer has been identified.

THE ALLIANCE FOR THE MENTALLY ILL (AMI) agrees to serve as lay advocates for the severely mentally ill in the jail. They will communicate with all parties of this agreement regarding the needs of the mentally ill.

PRE-TRIAL SERVICES agrees to communicate the legal status and court dates of the SEVERELY MENTALLY ILL to the appropriate agencies. They further agree to assist in expediting court dates as appropriate.

THE PUBLIC DEFENDER'S OFFICE agrees to work cooperatively with Pretrial Services in communicating the legal status of the cases involving the severely mentally ill to all appropriate agencies and to assist in expediting court dates. It is further agreed that this agency will also enter court orders for forensic evaluations as needed.

The COMMUNITY MENTAL HEALTH CENTER agrees to provide forensic evaluations, in a timely manner, as ordered by a criminal court judge, and to provide follow-up forensic services to severely mentally ill who are returned from the INPATIENT MENTAL HEALTH FACILITY following court ordered evaluations. It is further agreed that this agency will communicate the findings of the evaluation to the appropriate agency.

INPATIENT MENTAL HEALTH FACILITY agrees to provide treatment for the severely mentally ill who are referred from the jail by court order or on an emergency basis. It is further agreed that this agency will communicate with the MENTAL HEALTH AGENCY 1 and THE COMMUNITY MENTAL HEALTH CENTER staff regarding the mental and forensic status of the severely mentally ill.

FURTHER, the community mental health centers in the greater county area agree to designate a staff member to serve as a liaison for the incarcerated severely mentally ill who are receiving or have previously received mental health treatment at their facility. The liaison will

conduct face-to-face sessions with the severely mentally ill to determine their needs (i.e. housing, appointments, etc.) and to provide assistance in getting those needs met.

IT IS FURTHER UNDERSTOOD, that all liaisons will be available to MENTAL HEALTH AGENCY 1 employees to provide and receive background information, social history, psychiatric history, and any other pertinent information relative to the provision of quality care for the severely mentally ill. It is further agreed that the community mental health centers will work cooperatively to develop a system for back-up should a liaison for any particular agency be unavailable.

THE COUNTY SHERIFF'S DEPARTMENT agrees to assist the liaisons in receiving access to the severely mentally ill by providing them with the proper credentials (i.e. jail badges) and appropriate space within the jail to interview the consumer. It is further agreed that the Sheriff's Department will designate space within the jail to be used specifically for housing those individuals identified as severely mentally ill.

FURTHERMORE, it is agreed that in the performance of this Agreement no person shall on the grounds of race, creed, color, sex, age, disability, religious affiliation or national origin, be excluded from participation in, be denied the benefits of, or be subject to any discrimination under any programs or activity sponsored by the parties.

APPENDIX B

National Resources

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Linda Wood
National Institute of Corrections
Jail Division
1960 Industrial Circle, Suite A
Longmont, CO 80501
(800) 995-6429

National Resource Center on Homelessness and Mental Illness
Policy Research Associates, Inc.
262 Delaware Avenue
Delmar, NY 12054
(800) 444-7415

Charles Meeks
National Sheriffs Association
1450 Duke Street
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Sue Dickinson
National Alliance for the Mentally Ill
Forensic Network
202 Briarwood Drive
Simpsonsville, SC 29681
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Mental Health Services in Local Correctional Facilities
Staffing and Core Services Guidelines

March, 1994

Sponsoring Organizations

New York State Office of Mental Health
Bureau of Forensic Services
Bureau of Planning Assistance and Coordination

Conference of Local Mental Hygiene Directors

New York State Commission of Correction

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EXECUTIVE SUMMARY

This document contains jail Mental Health staffing and core service guidelines to plan for assessment, crisis intervention for persons with mental illness as they are being admitted to jail and ongoing treatment and release planning for persons with mental illness who remain incarcerated. The guidelines address only persons with severe and persistent mental illness and/or crisis service needs. They do not address court ordered evaluations*, substance abuse or diversion services. The document was prepared by the New York State Office of Mental Health, the NYS Conference of Mental Hygiene Directors and the NYS Commission of Correction with input from an advisory committee composed of NYS Office of Alcohol and Substance Abuse Services, New York City Department of Mental Health, Mental Retardation and Alcoholism Services, and New York City Department of Health, Correctional Health Services. It provides advice and guidelines to local governments for estimating the prevalence of mental illness in local jails as well as an organized way for examining mental health service need and assessing unmet services and staffing need. Although this document is not a mandate, counties are encouraged to use the methodology provided in this paper to develop relevant forensic sections as part of their short and long range Local Government Unit Plans.

In New York State, there are 79 local correctional facilities. During the past two decades, local jails in New York State have experienced more than 200% growth in population. However, growth in resources to support the mental health and other special service needs of persons incarcerated in these facilities has not kept pace with the tremendous growth in population. Combined, these facilities maintain custody of over 31,000 persons on an average day. Approximately 60% of these persons are awaiting trial. The majority of individuals incarcerated in a jail are residents of the county/municipality in which the jail is located. In New York State, as well as across this nation, jail mental health services have remained underdeveloped. There are no adequate standards on which to document service need and to develop meaningful plans. Furthermore, budgetary processes have not been expanded to include specific categories to fund jail mental health services. This paper recognizes that counties have a responsibility to provide mental health services in local correctional settings and, therefore, provides a mechanism to estimate the resources needed to meet the mental health needs of its county residents in their jails.

In developing mental health staffing expectations, various factors were considered. They included the expected prevalence of severe and persistent mental illness in jails; other factors influencing service demands; expert opinion on the staff time required to provide services; and an analysis of staffing patterns for exemplary jail mental health programs in New York State and nationally. Staffing expectations described in this paper are based on the assumption that the clinic treatment program and its array of services can address the typical service needs of most jails. However, it is recognized that if the clinic treatment model is utilized, a review of existing clinic treatment program requirements (especially QA regulations) will need to be conducted by OMH to make appropriate adaptations for jail settings. The recommended number of staff expected (excluding diversion) can be summarized by two formulas: (1) 2.1 FTE staff per 10,000 annual jail admissions for mental health assessment, crisis intervention services at admission and (2) 7.6 FTE staff per 1,000 average daily jail census for ongoing mental health treatment and support services following admission.

Quantifying the need for mental health services in jails is a complex issue that could be influenced by many variables to which these simple formulas may not be sensitive. While

we believe that these staffing formulas provide baselines to plan for an array of clinic treatment services for most localities, further work is needed to assess their applicability to large urban jails such as New York City Department of Corrections. Localities are encouraged to consider their unique differences in planning jail mental health services and to document these differences in their local plans.

* Staffing guidelines for court ordered evaluations are dictated by the Criminal Procedure Law.

INTRODUCTION

This document contains jail Mental Health staffing and core service guidelines to plan for assessment and crisis intervention for persons with mental illness as they are being admitted to jail and ongoing treatment and release planning for persons with mental illness who remain incarcerated. The guidelines address only persons with severe and persistent mental illness and/or crisis service needs. They do not address court ordered evaluations*, substance abuse or diversion services. The document was prepared by the New York State Office of Mental Health, the NYS Conference of Mental Hygiene Directors and the NYS Commission of Correction with input from an advisory committee composed of NYS Office of Alcohol and Substance Abuse Services, New York City Department of Mental Health, Mental Retardation and Alcoholism Services, and New York City Department of Health, Correctional Health Services. It provides advice and guidelines to local governments for estimating the prevalence of mental illness in local jails as well as an organized way for examining mental health service need and assessing unmet services and staffing need. Although this document is not a mandate, local governmental units are encouraged to use the methodology provided in this paper to develop relevant forensic sections of their Local Mental Health Plans.

In New York State, there are approximately 79 local correctional facilities. During the past two decades, local jails in New York State have experienced over 200% growth in population. However, resources to support the mental health and other special service needs of persons incarcerated in these facilities have not been commensurate with the tremendous growth in population. Combined, these facilities maintain custody of over 31,000 persons. Approximately 60% of these persons are awaiting trial while most of the remaining 40% are convicted and are either serving their sentences or are awaiting transfer to state correctional facilities. The majority of individuals incarcerated in a jail are residences of the county or municipality in which the jail is located.

In New York State, as well as across this nation, jail mental health services have remained underdeveloped. There are inadequate standards or baselines on which to document service need and to develop meaningful plans. Furthermore, budgetary processes have not been expanded to include specific categories to request resources for jail mental health services. This paper recognizes that counties have a responsibility to provide mental health services in local correctional settings jails and provides a mechanism to estimate the resources needed to meet the mental health needs of its county residents in their jails.

There are four major areas addressed within this paper:

1. Estimates of Prevalence: Persons with Serious Mental Illness, Substance Abuse Problems and Other Crisis-Related Problems within Local Jail Populations
2. Variances in Service Needs
3. Mental Health Services for Jails
4. Recommendations for Jail Mental Health Staffing

* Staffing guidelines for court ordered evaluations are dictated by the Criminal Procedure Law.

ESTIMATES OF PREVALENCE

Studies regarding the prevalence of serious mental illness in jails have found rates two to three times higher than in general population. A national review of the literature suggests that 6.3% may be a reasonable baseline for estimating prevalence of persons with severe and persistent mental illness in local jails. However, these data further suggest that the prevalence rate may vary considerably among counties, reaching a much higher rate in the large urban jails. These estimates are based primarily upon a study by Teplin (1990) and a survey by Torrey et al. (1992). Teplin found 6.3 percent of inmates currently met the diagnostic criteria for a severe mental disorder, defined as schizophrenia, major depression, or mania, but excluding substance abuse only. Torrey, in a survey of jail officials, estimated that 7.2% of jail inmates have a serious mental illness. Data from the Torrey survey for jails within New York State indicated that 6.5 percent of inmates have a serious mental illness, helping to corroborate the generalizability of Teplin's finding to New York.

The Torrey survey as well as other studies, (Shuckit, Herrman and Shuckit, 1977; Swank and Winer, 1976; Teplin, 1991) suggests differences in prevalence of serious mental illness among jail populations. Torrey found that the reported rates of serious mental illness were directly associated with the size of the average daily jail population: 3.3 percent in jails with fewer than 50 inmates, 4.4 percent in jails with 51-250 inmates, 7.3 percent in jails with 251-1,000 inmates, and 8.7 percent in jails with over 1,000 inmates (p. 28). The causes for this increased rate of prevalence may be explained by the fact that large urban jails are heavily populated by persons who are homeless. Homelessness greatly increases the potential for involvement with the criminal justice system. One-fourth to one-third of inmates in the New York City correctional system had been homeless at some time during the two months prior to admission, and 20% had been homeless the night before their admission (Michaels et al, 1992). Homeless populations have a high prevalence rate of serious mental illness. Michaels (1992) found that 50% of jail inmates who had ever been homeless during the past three years responded positively to at least one mental illness screening question, compared to 25% of never homeless inmates. Finally, most persons with serious mental disorders in jails also have substance abuse problems. Teplin (1994) found 74% of jail inmates with severe psychiatric disorders have co-occurring severe alcohol or substance abuse disorders.

In addition to the prevalence of serious mental illness, most jail populations have high suicide rates and large populations of persons who are experiencing other crises. Many of these individuals express suicidal ideation and/or are involved in self-abusive acts. Although they experience psychiatric conditions which may not be as disabling as serious mental illness, they require mental health treatment. Nationally, the suicide rate in jails is nine times greater than the general population (Hayes, 1989). In New York State, due primarily to the success of the Local Forensic Suicide Prevention Crisis Services Project (Cox, 1989), the suicide rate for jail inmates has been significantly reduced. In planning jail mental health services, therefore, it is critical to make provisions for persons with severe and persistent mental illness as well as those individuals, who while not classified as having a serious mental illness, experience periodic psychiatric crises which require immediate intervention and treatment.

VARIANCE IN SERVICE NEEDS

It is expected that there will be variance among counties in regard to prevalence of mental illness in local jails and in the type and intensity of mental health service need. It is likely that communities with coordinated mental health and criminal justice systems, including mental health jail diversion programs, may reduce the rates of persons with serious mental illness within their jails. For example, mental health officials in Albany County have reported a prevalence rate of five percent. They attribute this rate to the successful efforts of a mobile crisis team and intensive case management to divert and prevent persons with serious mental illness from becoming incarcerated (Albany County DMH, 1993). In regard to service needs, jails with high turnover and a short average length of incarceration will most likely need more assessment and crisis intervention capacity in their mental health service design. Similarly, facilities with longer average length of incarcerations may have more emphasis on ongoing treatment services. Thus, capacity and volume of admissions, while not decreasing the possible range of services, can affect the use of specific services and the types of staffing of the mental health service.

Large urban jails, especially those with high concentrations of homeless populations should be sensitive to differences in intensity and type. The high concentration (daily census) of persons with severe and persistent mental illness and persons with assessment and crisis needs requires additional and more intensive programs and services than the clinic model addressed in this paper. Continuing treatment programs and special residential crisis intervention service units may also be needed and appropriate in urban jail settings. Finally, supervisory and administrative staff required to manage large jail mental health programs need to be added in addition to clinical staff as estimated by the use of these guidelines.

MENTAL HEALTH SERVICE FOR JAILS

Planning for and providing jail mental health services is a shared responsibility between the local mental health and corrections systems. The need for timely assessment, intervention and ongoing monitoring of inmates is driven by the massive volume of jail admissions and precludes either system from being able to meet the needs alone. Supporting the need for these services are the NYS Commission of Correction Minimum Standards for Management of County Jails and Penitentiaries which require correctional officials to make "definite arrangements" with mental service providers thereby ensuring that "maximum use should be made of community medical and mental health facilities, services and personnel."

Services in local jails should achieve early identification and crisis intervention for persons who are suicidal and/or in need of psychiatric inpatient services. In addition services are needed to reduce symptoms, improve functioning and provide support for persons with severe and persistent mental illness who remain incarcerated. In achieving these goals, an array of services needs to be available. The array described in these guidelines is based upon five critical assumptions.

1. Clinic treatment program and its associated services are most frequently needed in local jails.

2. The array of clinic treatment services and their intensity may vary based upon local differences and needs; additionally, some of the regulations governing these services

will need to be modified to reflect jail environments.

3. Some jails (especially in large urban facilities) may need other types of mental health programs/services. Staffing to provide these programs will need to be separately built into the methodology offered in these guidelines. For example, for correctional facilities with crisis residential units, it is estimated each unit of 12 - 24 beds would require an additional 7.5 mental health staff positions.

4. Discrete correctional staff functions and services are essential to the care of persons with mental illness in local jails.

Mental Health Services Needed in Local Jails

The methodology for estimating jail mental health staffing resources is based on services as delineated below in sections under 1) Screening, Assessment and Crisis Intervention at Admission and 2) Treatment and Support for Inmates with Severe and Persistent Mental Illness who Remain Incarcerated. **Not included in this formula are program administration and other core services such as Diversion and Substance Abuse Services.**

1. **Screening, Assessment and Crisis Intervention at Admission** for inmates with serious mental illness and inmates in crisis.

2. **Treatment and Support for Inmates with Severe and Persistent Mental Illness who Remain Incarcerated**

   a. **Assessment and Treatment Planning**
   b. **Crisis Intervention**
   c. **Medication Therapy**
   d. **Verbal Therapies:** Ongoing service for inmates with serious mental illness and/or acute symptomology.
   e. **Symptom Management**
   f. **Case Management**
   g. **Clinical Support Services Involving Correctional Officers as Collaterals**
   h. **Pre-Release Planning:** Discharge planning for all inmates who are released to the community or sentenced to NYSDOCS who have a serious mental illness and inmates who attempted suicide or were hospitalized during current or recent incarcerations. This would include assuring coordination of inpatient admissions and discharges through the Custodial Transfer Information form (3610.A) required by CL 601A.

3. **Diversion Services** for appropriate persons with mental illness from incarceration either through dedicated mental health staffing, referral for substance abuse services, and/or in conjunction with existing probations and alternative to incarceration agencies. These mental health advocacy services focus on ensuring equal appropriate access to criminal justice options and implementation of the community based treatment plans developed as part of pre-release planning. These advocacy services can be focused on one or more of the following criminal justice decision points:

- At admission and release points for police lock-ups and county/municipal jails.
- In decision points for local courts and the criminal justice process (i.e arraignment, plea bargaining, disposition and sentencing).
- In the eligibility determination process for probation and alternatives to incarceration programs.

These diversion programs and activities are designed to function within each unique local criminal justice system and, depending upon the complexity of the individual's situation, can range greatly in intensity of staff time. The development of diversion programs for persons with severe and persistent mental illness is a collaboratrive process between local mental health and criminal justice systems. Information concerning establishing diversion programs can be found in the OMH Manual of Criminal Justice Interventions for Mental Health Providers (1993).

3. **Correctional Services for Detection, Symptom Management and Supervision:**

Detection, referral and supervision at intake and throughout incarceration are primarily correctional and medical staff functions related to inmates with severe and persistent mental illness, inmates at risk of suicide and inmates who are intoxicated or withdrawing from substances. These activities are required pursuant to § 7003 and §7013 of NYSCOC Minimum Standards for Local Correctional Facilities. They must include:

a) Detection and referral at intake and throughout incarceration

b) Supervision, especially for inmates, either 1) maintained in a special mental health unit/cell, and/or 2) under more intense watch due to suicidal ideation or other acute symptomology.

c) Special Mental Health Housing

d) Delivery of psychotropic medication and monitoring their side effects.

e) Preparing and transmitting the Custodial Transfer Information form (3610.A) required by CL 601A.

f) Notification of family and other visitors to refer inmates who have had a history of suicide or who they believe to be suicidal (e.g., post sign in visitor's room).

The above services must be supported by Corrections and Mental Health through:

g) Appropriate training for medical staff and officers assigned to classification and housing unit areas, especially those in special mental health housing units. Training should cover at least the following areas: screening for signs of mental illness and suicide risk including, for local correctional facilities not in the NYC area, utilization of Suicide Prevention Screening Guidelines 330

ADM, and psychotropic medications and their side effects, and strategies for communicating and safely managing persons with servere and persistent mental illness and/or in psychiatric crisis.

h) Orientation for intake and housing unit officers, medical staff, family and other visitors and court personnel to procedures and required forms for receiving inmates whose behavior/history suggests the need for emergency or non-emergency mental health care.

i) Ensuring suicide prevention and other precautions for managing inmates are shared with correctional staff assigned to their supervision and recorded by these staff in the facility log book.

j) Keeping separate medical and mental health records, but coordinating sharing of appropriate information to assure continuity of care within the facility, with exterior psychiatric inpatient services, and community based mental health providers upon release. This would also include accessing clinical information from prior or current mental health providers.

k) Transfer of clinical records, such as prior mental health treatment

RECOMMENDATIONS FOR JAIL MENTAL HEALTH STAFFING

Mental health staffing formulas contained in this paper address only screening, assessment and crisis intervention; and ongoing treatment and support. They do not address diversion services, court order evaluations or substance abuse services. Various factors were considered in developing these formulas, especially expected prevalence of severe and persistent mental illness in jails, expert opinion on staff time required, and analysis of staffing patterns for jail mental health programs recognized in a national survey for their high quality. The resulting number of staff persons expected can be summarized with two formulas:

- 2.1 FTE staff are recommended per 10,000 annual jail admissions, and
- 7.6 FTE staff for mental health treatment and support are recommended per 1,000 average daily jail census.

Figure 1 shows how recommended staff levels may be calculated for each individual jail. Annual jail admissions is multiplied by an admissions staffing factor to derive recommended staffing for screening, assessment and crisis intervention. Average daily census is multiplied by a census staffing factor to determine recommended staffing for treatment and support. Local conditions are expected to affect staffing requirements. The final sections of this paper describe how localities may apply this framework to reflect their unique circumstances.

Screening, Assessment, and Crisis Intervention

The number of full-time equivalent staff persons (FTEs) needed for screening, assessment and crisis intervention (admissions staffing factor) is dependent upon three considerations:

the number of persons requiring mental health assessment or crisis intervention; the duration of those services; and average weekly service hours per FTE. Figure 2 displays how staffing recommendations may be calculated using assumed values for these three elements. Assumptions are derived from available data or expert opinion, as follows:

- One mental health screening, assessment or crisis intervention contact is expected for every four inmates admitted. (See Table 1; the ratio of 0.25 corresponds to the 80th percentile averaged for 1988 and 1989 respectively.)

- Time required to provide screening, assessment and crisis services is expected to average one hour per contact.

- An FTE mental health worker is assumed to provide an average of 5 service hours per day for 234 days per year, resulting in an average of 22.5 hours per week. Service hours include direct, collateral, and advocacy contacts, but not paperwork and other administrative time.

When the above assumptions are used in the formula provided in Figure 2, we calculated that 2.1 staff are needed for every 10,000 admissions. Shaded boxes in the figure indicate where assumed values may be replaced with estimates derived from local assessments.

Treatment and Support

The number of FTEs needed for treatment and support (census staffing factor) is expected to depend on four parameters: prevalence of severe and persistent mental illness (SPMI) among the jail census; weekly service hours required by persons with SPMI; weekly service hours required by persons without SPMI; and average weekly treatment and support hours per FTE. Figure 3 illustrates the calculation of staffing guidelines for treatment and support. The following values are assumed in developing staffing recommendations:

- As described above, 6.3% of the average daily jail census is expected to be persons with SPMI.

- Each inmate with SPMI is assumed to need multiple weekly direct service, and collateral contacts per week, totaling approximately two hours on the average.

- One out of every seven or eight inmates without SPMI is expected to need some mental health intervention during a typical week, lasting an average of 30 minutes.

- An FTE mental health worker is assumed to provide an average of five direct, collateral, and advocacy staff hours per day for 234 days per year, resulting in an average of 22.5 staff hours per week. Since a small amount of staff hours may involve groups of inmates (e.g., one half-hour group for five-six inmates per week), the average number of treatment and support hours *received by inmates* is assumed to be 24.75 per week.

When the above assumptions are used in the formula provided in Figure 3 it is calculated that 7.6 staff are needed per 1,000 average daily census.

The assumptions described above and shown in Figures 2 and 3 lead to a Statewide inmate-to-staff ratio of 107. This ratio compares favorably with seven jail mental health programs recognized in a nationwide survey (Torrey, et al., 1992) for their high quality care (Table 2). Based on average daily jail census and annual admissions from the year ending September, 1992, recommended mental health staffing for each county is provided in Table 3.

Local Assessment Of Jail Mental Health Staffing

There are a number of reasons why the assumed values used to calculate jail staffing recommendations may not be adequate. For example:

- The prevalence of severe and persistent mental illness may be higher or lower than suggested by the research; for example lower rates of SPMI may be found in areas with well developed and coordinated mental health service systems, including jail diversion programs.
- Stressful jail environments (e.g. overcrowded space) may increase demand for mental health assessment and crisis intervention.
- Staffing conditions, average length of incarceration, or the amount of training provided to mental health staff may affect the time required to conduct screenings and assessments, or to provide treatment and support.
- Inadequate levels of correctional staffing may increase duties of mental health staff.
- Jails with unusually large numbers of admissions and shorter jail stays may need to devote more time to mental health assessments and pre-release planning.
- Local labor contracts and work practices will determine weekly employment hours per FTE, thereby affecting weekly service hours per FTE.

Localities are encouraged to assess local circumstances influencing jail mental health services and develop staffing plans appropriate to area conditions. Figures 2 and 3 provide a tool for localities to adjust staffing expectations to local needs and circumstances within the planning framework presented in this paper. Unmet services and staffing need is calculated by totalling needed FTEs from Figure 1 (or, for localities using revised assumptions, from Figures 2 and 3), and subtracting current FTEs from the total. Current FTEs consists of both on site and off site (e.g. ICM, Mobile Crisis) mental health staff who provide mental health services to the jail population.

Resources

This document was developed with the goal of providing a method for estimating, and at the same time not mandating, the "ideal" amount of staffing and clinic services to meet the needs of county residents in local jails. The OMH estimates of need should not be interpreted as a mandated level of service. Local governmental units must determine for themselves the most appropriate levels of service to be provided to persons in jails, as well as the best way to organize those services. In a time of scarce resources and competing

demands it is not expected that localities will be able to reach these estimates immediately. Localities may not be able to find a single source of funding to support these services. It is likely that a mix of state and local resources from mental health, criminal justice, alcoholism/substance abuse, and possibly other human services will be necessary to achieve full funding.

Further work is needed to understand how unique circumstances in specific local areas may lead to different staffing requirements. The authors welcome recommendations, and in particular, values and explanations for the substitutions which will refine the assumptions which were made when calculating staffing recommendations. Please send comments to:

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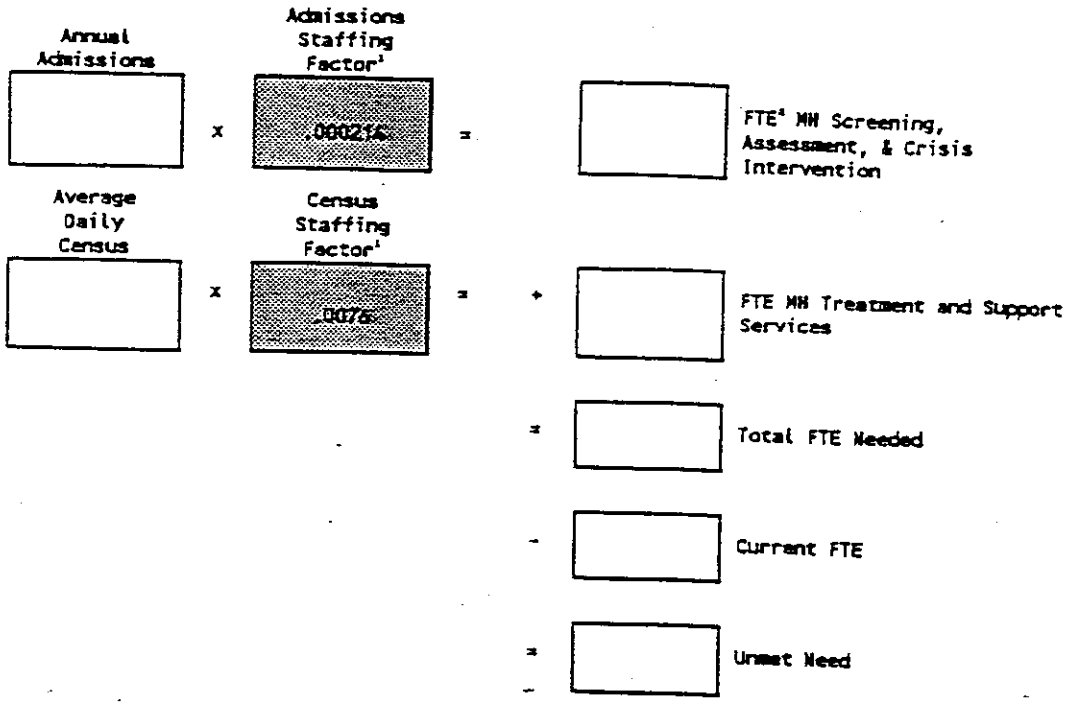
Figure 1: Jail Mental Health Staffing Guidelines



[1] Different values may be used substituted to reflect local conditions. Please see figures 2 and 3 for calculation of these staffing factors.

[2] Full time equivalent staff persons.

Figure 2
Admissions Staffing Factor - To calculate FTEs for mental health screening, assessment, and crisis intervention

A. Mental health assessments[1] per admission		.25
B. Mental health assessment duration, including administrative time		1.0 hr.
C. Average weekly assessment hours per FTE[2]		22.5
D. Admissions Staffing Factor	$\frac{(A \times B)}{(C \times 52 \text{ wks})}$	.000214

Figure 3
Census Staffing Factor - To calculate FTEs for mental health treatment and support

A. Percent of inmate population (average daily census) with SPMI		6.3%
B. Percent of inmate population without SPMI (100% - A)		93.7%
C. Weekly treatment and support service hours per SPMI		2.0
D. Weekly treatment and support service hours per non-SPMI		.067
E. Wkly. treatment and support service hrs. inmates receive per FTE[3]		24.75
F. Census Staffing Factor	$\frac{(A \times C)+(B \times D)}{E}$	.0076

[1] In Figure 1, "assessment" is meant to include screening, assessment, and crisis intervention services.

[2] Assumes 5 hours for typical days and 26 days annual leave; i.e. 234 working days.

[3] Assumes an average of 22.5 *staff* hours per week. Also assumes an average FTE provides one weekly half-hour group for 5-6 inmates. Therefore, the average number of hours *received by inmates* is assumed to be 24.75 per FTE. When entering new value, include direct, collateral, and advocacy services, but not time spent in administrative activities; and factor in multiple service hours delivered through group intervention.

Table 1
Jail Inmates Admitted to Mental Health Services, Receiving Assessment But Not Admitted, and Estimated Assessments Conducted, Number and Per 100 total Jail Admissions, by County, 1988 and 1989

Year/ County	Admitted to MH Services	Assessment Only	Estimated Total Assessments	Total Jail Admissions	Assess-ments per Admission	Rank	Percentile
1988							
Chautauqua	25	25	75	1756	0.04	1	0.05
Ontario	2	71	75	1596	0.05	2	0.10
Clinton	13	58	84	1545	0.05	3	0.15
Oneida	32	67	131	2408	0.05	4	0.20
Livingston	16	51	83	1097	0.08	5	0.25
Schenectady	34	128	196	2429	0.08	6	0.30
St. Lawrence	24	50	98	1207	0.08	7	0.35
Montgomery	7	65	79	853	0.09	8	0.40
Sullivan	45	114	204	2037	0.10	9	0.45
Wayne	4	145	153	1211	0.13	10	0.50
Wyoming	23	7	53	370	0.14	11	0.55
Steuben	18	120	156	832	0.19	12	0.60
Putnam	25	111	161	771	0.21	13	0.65
Ulster	139	231	509	2431	0.21	14	0.70
Tompkins	66	274	406	1507	0.27	15	0.75
Herkimer	21	116	158	513	0.31	16	0.80
Albany	121	759	1001	3076	0.33	17	0.85
Schuyler	19	26	64	184	0.35	18	0.90
Cortland	36	209	281	784	0.36	19	0.95
Nassau	4059	960	9078	10294	0.88	20	1.00
1989							
Schuyler	15	35	65	2725	0.02	1	0.04
Rensselaer	5	50	60	1895	0.03	2	0.08
Wyoming	4	5	13	378	0.03	3	0.12
Chautauqua	26	14	66	1877	0.04	4	0.16
Montgomery	3	48	54	1284	0.04	5	0.20
Oneida	17	87	121	2663	0.05	6	0.24
Wayne	4	71	79	1280	0.06	7	0.28
St. Lawrence	4	8	16	249	0.06	8	0.32
Ontario	7	88	102	1441	0.07	9	0.36
Clinton	20	85	125	1349	0.09	10	0.40
Chenango	22	5	49	496	0.10	11	0.44
Cattaraugus	59	8	126	1007	0.13	12	0.48
Livingston	18	76	112	888	0.13	13	0.52
Herkimer	4	96	104	697	0.15	14	0.56
Ulster	122	130	374	2373	0.16	15	0.60
Allegany	20	57	97	603	0.16	16	0.64
Steuben	26	125	177	1083	0.16	17	0.68
Schenectady	42	150	234	1319	0.18	18	0.72
Putnam	31	90	152	845	0.18	19	0.76
Albany	25	762	812	4115	0.20	20	0.80
Sullivan	170	74	414	1939	0.21	21	0.84
Tompkins	30	200	260	989	0.26	22	0.88
Cortland	60	250	370	703	0.53	23	0.92
Nassau	3972	706	8650	11704	0.74	24	0.96
Erie	4121	589	8831	11885	0.74	25	1.00

In Table 1, "assessment" is meant to include screening, assessment, and crisis intervention services.

Data obtained from counties by OMH Bureau of Forensic Services. Data unavailable from counties not shown. Screenings estimated as ((2 * Admissions to MH Services) + (Assessment Only)).

Table 3: Estimates of Census, Annual Admissions, and Needed Staff					
			Staff Recommended for Clinic Services (FTE)		
County	Average Daily Census (9/92)	Annual Admissions (9/92)	Treatment and Support	Screening, Assessment, and Crisis Intervention	Staff Total
Albany	622	4,738	4.7	1.0	5.7
Allegany	43	614	0.3	0.1	0.4
Broome	236	2,590	1.8	0.6	2.4
Cattaraugus	80	1,038	0.6	0.2	0.8
Cayuga	69	1,201	0.5	0.3	0.8
Chautauqua	122	1,807	0.9	0.4	1.3
Chemung	154	1,605	1.2	0.3	1.5
Chenango	27	521	0.2	0.1	0.3
Clinton	66	1,765	0.5	0.4	0.9
Columbia	84	1,261	0.6	0.3	0.9
Cortland	40	671	0.3	0.1	0.4
Delaware	19	519	0.1	0.1	0.2
Dutchess	237	3,196	1.8	0.7	2.5
Erie	1,068	15,671	8.1	3.4	11.5
Essex	12	291	0.1	0.1	0.2
Franklin	34	535	0.3	0.1	0.4
Fulton	44	568	0.3	0.1	0.4
Genesee	60	975	0.5	0.2	0.7
Greene	32	880	0.2	0.2	0.4
Hamilton	5	64	0.0	0.0	0.0
Herkimer	36	632	0.3	0.1	0.4
Jefferson	124	2,013	0.9	0.4	1.3
Lewis	25	416	0.2	0.1	0.3
Livingston	56	977	0.4	0.2	0.6
Madison	59	1,134	0.4	0.2	0.6
Monroe	1,012	13,057	7.7	2.8	10.5
Montgomery	102	1,057	0.8	0.2	1.0
Nassau	1,702	11,493	12.9	2.5	15.4
Niagara	244	3,150	1.9	0.7	2.6
Oneida	322	3,430	2.4	0.7	3.1
Onondaga	633	9,515	4.8	2.0	6.8
Ontario	117	1,654	0.9	0.4	1.3
Orange	409	6,029	3.1	1.3	4.4
Orleans	75	972	0.6	0.2	0.8
Oswego	86	1,249	0.7	0.3	1.0
Otsego	43	461	0.3	0.1	0.4
Putnam	45	887	0.3	0.2	0.5
Rensselaer	145	1,987	1.1	0.4	1.5

Table 3: Estimates of Census, Annual Admissions, and Needed Staff					
			Staff Recommended for Clinic Services (FTE)		
County	Average Daily Census (9/92)	Annual Admissions (9/92)	Treatment and Support	Screening, Assessment, and Crisis Intervention	Staff Total
Rockland	158	2,489	1.2	0.5	1.7
St Lawrence	68	858	0.5	0.2	0.7
Saratoga	153	1,943	1.2	0.4	1.6
Schenectady	210	3,200	1.6	0.7	2.3
Schoharie	22	474	0.2	0.1	0.3
Schuyler	13	273	0.1	0.1	0.2
Seneca	33	618	0.3	0.1	0.4
Steuben	78	1,075	0.6	0.2	0.8
Suffolk	1,184	11,100	9.0	2.4	11.4
Sullivan	162	1,644	1.2	0.4	1.6
Tioga	56	702	0.4	0.2	0.6
Tompkins	59	945	0.4	0.2	0.6
Ulster	151	2,129	1.1	0.5	1.6
Warren	52	869	0.4	0.2	0.6
Washington	36	747	0.3	0.2	0.5
Wayne	78	1,441	0.6	0.3	0.9
Westchester	1,285	12,350	9.8	2.6	12.4
Wyoming	42	345	0.3	0.1	0.4
Yates	38	403	0.3	0.1	0.4
New York City[1]	18,552	109,641	140.9	23.5	164.4
NYS Total	30,719	253,869	233.1	54.5	287.6

[1] Census and admissions data not available at the borough level for NYC jails.